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| Faster diagnostic pathways |
| Implementing a timed breast cancer diagnostic pathway |
| Guidance for local health and care systems |
| Version 1.4 - 22 August 2022 |

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# Best practice timed diagnostic pathways

Best practice timed pathways support the on-going improvement effort to shorten diagnosis pathways, reduce variation, improve people’s experience of care, and meet the [Faster Diagnosis Standard](https://www.england.nhs.uk/cancer/early-diagnosis/) (FDS). The guidance will support Cancer Alliances and constituent organisations to adopt consistent, system-wide approaches to managing this diagnostic pathway.

This guidance sets out how diagnosis within 28-days can be achieved for the suspected breast cancer pathway. Alongside the pathway itself, resources are highlighted to support implementation of the pathways.

This breast pathway is part of a [series](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/), published since April 2018. From previous pathways implemented by Cancer Alliances, [Implementation Guidance](https://future.nhs.uk/canc/view?objectId=27248560) was shared in June 2021, identifying areas that are key to success, such as setting up with clinical and operational engagement, auditing pathways, allocating project management resources, ensuring leadership, analysing data, and sharing successes.

This guidance complements existing resources such as NICE Guidelines (including NG12) and should therefore be read alongside such guidance.

While the guidance stipulates recommended clinical actions and timings, we recognise that this will not apply to all people in all circumstances, and that responsibility for clinical decision making remains with local clinical teams with the knowledge and expertise to make appropriate decisions and policies.

The pathway in this document was developed by a multi-disciplinary consensus group with clinical leaders from local and specialist services across England, expert advice from Cancer Alliances, and people with lived experience.

For any questions about this document please email [england.cancerpolicy@nhs.net](mailto:england.cancerpolicy@nhs.net).

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## Cover note

This Best Practice Times Pathway (BPTP) is being published at a time of huge pressure on breast services around the country, with the Faster Diagnosis Standard for breast referrals currently not being met. The main challenge is a significant increase in referrals, particularly in younger age groups with a low risk of cancer.

The ‘pinch point’ is the one stop clinic (OSC), where there is insufficient capacity, and insufficient staff to run these in the numbers required.

This Best Practice Timed Pathway specifically addresses this issue and represents a fundamental departure from historic practise by mandating triage of all referrals and diversion of patients away from the pinch point of the one stop clinic for those at low risk of a cancer diagnosis and without red flag symptoms:

* This makes best use of the OSC for those who need examination, imaging and potential biopsy
* Ensures those at low risk are seen in an appropriate setting, and avoid the unnecessary imaging that often occurs in the OSC, most of these patients can be seen by a single clinician, and do not need the multi-disciplinary resource of the OSC

This will ensure:

* Best care for patients
* Best use of the OSC resource
* Reduce unnecessary and inappropriate imaging

New pathways for patient management should be evaluated to ensure safety and patient satisfaction. The Association of Breast Surgery (via the iBRANetwork) is currently running a platform evaluation study – The Aspire Study – for evaluation of new pathways, do get in touch to join this study for your pathway evaluation.

The Task and Finish Group recognises that the BPTP requires sufficient workforce to implement and the Group supports a full strategic review of workforce requirements to ensure that requirements are audited and actions put in place to meet long term workforce needs and to fill the requirement gap in the interim.

A cancer diagnosis (without receptors) is no longer sufficient to manage patients with breast cancer and therefore tumour receptor status has been incorporated into the pathway to allow treatment planning by day 28, which goes further than achieving the Faster Diagnosis Standard.

The Group recognises that localities will have differing practices with regard to ‘cancer not suspected.’ It is important, therefore, that it is understood that the timepoints and pathway suggestions in the pathway are best practice guidance to achieve the FDS.

## Acknowledgements

This guidance was developed by the NHS Cancer Programme and builds on experience and expertise provided by the Breast Task and Finish Group membership outlined below which includes clinical representatives, operational representatives, patient and charity representatives, and the NHS Cancer Programme.

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# The Faster Diagnosis Standard

We committed in the [NHS Long Term Plan](https://www.longtermplan.nhs.uk/) to provide a faster diagnosis for people through the introduction of the [Faster Diagnosis Standard](https://www.england.nhs.uk/cancer/early-diagnosis/) (FDS). This standard will ensure people are told they have cancer, or that cancer is excluded, within a maximum of 28 days from referral. The new standard is intended to:

* reduce the time between referral and diagnosis of cancer. The timed pathway sets the expectation that a breast cancer diagnosis includes the tumour receptor status, i.e. the oestrogen receptor (ER), the HER2 receptor status, and in some centres, +/- the progesterone receptor (PR). It is recognised that if HER2 fluorescent in-situ hybridisation (FISH/ISH) is required, this may not be available for a further 7 days. In this case, a diagnosis should still be provided within 28 days without FISH/ISH if it is not available in time. Communicating the cancer or non-cancer diagnosis to the patient is required to stop the 28 day clock as specified within the CWT v12 guidance.
* help to reduce anxiety for the cohort of people who will be diagnosed with cancer or have cancer ruled out.
* reduce unwarranted variation in England by understanding how long it is taking people to receive a diagnosis or have cancer ruled out.
* represent a significant improvement on the current two-week wait to first appointment target, and a more person-centred performance standard.

FDS performance data, including a breakdown by suspected cancer pathway, has been published since June 2021, and faster, more streamlined pathways will be a priority.

The challenge for those referred with breast symptoms is to manage all patients appropriately. Those with suspected cancer should be seen in a ‘one stop clinic’ with same day access to clinical examination, mammography, ultrasound and biopsy.

For those referred urgently with breast symptoms where cancer is not initially suspected, such as breast pain in the absence of any other symptoms, or gynaecomastia, each unit, working with their Cancer Alliance, should review their current practice and ensure it aligns with the guidance in this document. The purpose of the ‘cancer not suspected’ pathways is to reduce unnecessary and inappropriate imaging, and ensure only appropriate referrals are sent via the ‘cancer suspected’ route. A number of different models have been suggested e.g. page 31 and appendix B of [Breast GIRFT Programme National Speciality Report](https://associationofbreastsurgery.org.uk/media/374565/girft-report-2021.pdf). Any new models need robust evaluation to ensure they meet the needs of patients. The Association of Breast Surgery (ABS) are developing a platform to support the evaluation of breast pain pathways, more information on which is available [here](https://associationofbreastsurgery.org.uk/professionals/clinical/breast-pain-pathways/).

As the key system-wide organisations for cancer services, Cancer Alliances will need to work across the local system to ensure that implementation is prioritised by senior stakeholders, clinical leaders, and operational colleagues, and that capacity is optimised to enable the standard to be delivered.

The FDS has been formally performance managed since October 2021 activity, in line with cancer services recovery, with an initial threshold of 75 per cent. Cancer Alliances will need to ensure that they have plans to meet the threshold, which will need to be increased in subsequent years if we are to contribute to achieving the early diagnosis ambitions in the [NHS Long Term Plan](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf).

We are focused on increasing the delivery of the high-performing breast pathway, to see high performance on the Faster Diagnosis Standard overall.

**Figure 1: FDS performance for breast v all suspected cancer referral routes, April 2021 to February 2022**

# The case for change

Breast cancer is the second most common cause of cancer in England affecting more than 48,000 people each year. Suspicion of breast cancer is the most common suspected urgent referral type in England with more than 430,000 suspected breast cancer referrals a year, representing around 20% of all urgent suspected referrals in 2020/21.

Between April 2021 and February 2022, 87% of 597,955 people received a communication of diagnosis within 28 days of referral. This relates to all FDS cohorts, suspected breast, breast screening, and breast symptomatic\*. Breast performance is higher than general performance across specialties however there is some variation across Cancer Alliances with a range of 77% to 95%. This has resulted in more than 40,000 people in nine months receiving a delayed diagnosis. Although this reflects the early COVID recovery period and may improve, it is important to address and mitigate any inequities underlying this disparity.

Between April 2020 and March 2021, 85% of people (19,985) diagnosed with breast cancer on an urgent referral pathway commenced treatment within 62 days of referral. This resulted in more than 3,600 people breaching the standard. However, this pathway has historically high performance, which this guidance aims to support.

**Figure 2: Breast 62-day referral to treatment Cancer Waiting Times data for England, 2018/19 Q1 to 2021/22 Q4**

**Figure 3: Breast 2WW referral to treatment Cancer Waiting Times data for England, 2018/19 Q1 to 2021/22 Q4**

Creating streamlined and efficient pathways, including for those in whom breast cancer is not suspected, has the potential to help reduce overall waiting times and the considerable variation currently seen across the country. This pathway intends to reduce the pressure on one stop clinics, with less inappropriate imaging, therefore less resource used, and less of the most pressured resource ie radiology.

Alongside adoption of the best practice timed pathway, Cancer Alliances must ensure the appropriate resources and capacity are in place to deliver high-quality services to more people. This includes having sufficient capacity within pathology services (medical and scientific) to analyse and deliver diagnostic results, including information on tumour receptor status, in a timely way. The document cannot prescribe exactly how all aspects of the service are delivered, Cancer Alliances must utilise primary care and secondary care teams to best deliver within their geographies.

It is important to consider workforce planning especially within the breast service given its high reliance on diagnostics to meet increasing demand and ensure best utilisation of the highly skilled workforce. The aim of this document is to address the clinicial pathway, however existing workstreams within NHS England are reviewing workforce planning. The system is encouraged to link into these workstreams to support implementation of this clinical pathway. The most recent [Royal College of Radiologists census](https://www.rcr.ac.uk/census2021) (2021) indicated the consultant radiologist workforce shortfall currently stands at 29% across all sub-specialty groups.

Similarly, the Royal College of Pathologists 2017 Workforce Survey found only 3% of Histopathology departments had enough consultant pathologists to meet demand and almost [1 in 6 posts were covered by locums or were vacant](https://www.rcpath.org/discover-pathology/news/college-report-finds-severe-staff-shortages-across-services-vital-to-cancer-diagnosis.html). In addition, there is presently a deficiency in the number of histopathology laboratory scientific staff, which is also influencing the capacity of departments to deliver results in a timely manner. It is important to note there is also a shortage of biomedical scientists impacting workforce.

# Actions for cancer alliances

**Cancer Alliances on behalf of ICSs**, are asked in 2022/23 to:

* Complete any outstanding work on the post-pandemic cancer recovery objectives;
* Ensure there is sufficient diagnostic and treatment capacity to meet recovering levels of demand given breast referral volumes have already exceeded pre-pandemic levels. This includes freeing up diagnostic activity .
* Improve performance against all cancer standards;
* Make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower;
* Increase the recruitment and retention of the NHS breast cancer workforce including, breast clinical radiology consultants, breast [clinical oncologists](https://www.rcr.ac.uk/clinical-oncology/rcr-clinical-oncology-census-report-2021), pathologists, clinical nurse specialists, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce.
* Ensure adequate resourcing to review and monitor FDS performance data across all referral pathways including screening, and examine alternative options to overcome workforce issues.
* Ensure that all patients with suspected cancer are seen in a one stop clinic with access to clinical examination, mammography, and ultrasound (with same day reporting) and biopsy.
* Ensure that appropriate, properly resourced, timed and fully evaluated pathways are in place for those patients with breast symptoms where cancer is not suspected.
* Work with GPs and the local population to:
  + refer on the appropriate pathway in line with NICE and NHS England guidance.

**NHS England** provides support, funding and guidance to help Cancer Alliances improve outcomes and reduce variation. The following support is available:

* Funding and programme management to support delivery to achieve the Faster Diagnosis Standard and best practice timed pathway milestones;
* Implementation Guidance for achieving pathways; and
* Collaboration and networking events to share best practice.
* For the setting up of alternative timed pathways for those in whom breast cancer is not suspected, and evaluation of their effectiveness in meeting patients’ needs and impact on breast cancer pathways.

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| “The pathway for most people, from referral by the Primary Care clinician or from a screening service to diagnosis or the exclusion of breast cancer is straightforward.  However, large and increasing volumes means that effective and robust capacity and demand analysis is required to ensure that resources are appropriate, and that networked support is available. Addressing workforce shortages nationally, and effective administration of the pathway, including excellent support for patients and timely access to Clinical Nurse Specialist (CNS) is also required.”  **Dr Catherine Harper-Wynne,** on behalf of the Breast Task and Finish Group, NHS Cancer Programme. |

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| “The team have worked hard to ensure that the FDS will provide a better experience to the patient compared to the 2WW, not only by achieving a diagnosis in a shorter time but notably with the inclusion of receptor status in the diagnosis in order to meet the standard. This means the diagnosis is much more meaningful to the patient as it will allow more information and an initial treatment plan to be discussed at the same time as being told you have cancer. Waiting, fear of the unknown and lack of ability to plan ahead are incredibly difficult parts of waiting to hear about a cancer diagnosis, so the Breast FDS has been designed to minimise that as far as possible and ensure patients on this pathway can get the meaningful information they need as quickly as possible.”  **Jo Chambers,** Patient and Public Voice Forum Member,on behalf of the Breast Task and Finish Group, NHS Cancer Programme. |

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| “We need a better standard for supporting patients for quicker and more effective diagnosis. Our group have worked hard to make sure that patients are going to be supported better with a more rapid diagnostic system. Managing patient expectations and supporting patients with effective communication is the key to the way forward.”  **Jo Taylor,** Patient and Public Voice Forum Member,on behalf of the Breast Task and Finish Group, NHS Cancer Programme. |

# Benefits of pathway change

**For Patients and Unpaid Carers**

* For those in whom cancer is suspected, faster access to the one stop clinic with access to triple diagnostic assessment in a single hospital visit, may reduce the anxiety and uncertainty of a possible cancer diagnosis, with less time between urgent referral and receiving the outcome of diagnostic tests
* Improved patient experience with as few visits to the hospital as possible, ideally to specialist centres where available, and avoiding emergency admission
* Appropriate management and support for those in whom breast cancer is not suspected within the same 28-day timeframe

**Experience of Care**

* Patients and Carers know they are urgently referred for investigation of suspected cancer and should expect a diagnosis and to agree a management plan within 28-days. For some patients this may include further diagnostics (such as specialised biopsies or breast MRI imaging), and these further tests should also be available in time to start optimal treatment within 62-days of initial urgent referral
* Ensure that patients and carers’ ability to attend appointments is taken into account and additional support is offered to help with this, for example providing translation services, where necessary
* Patients are communicated with clearly, understand the information provided, and are given additional support, such as access to a CNS or a patient navigator
* Care and support that meets the needs of those in whom breast cancer is not suspected but are experiencing significant issues with their breasts, using evidence based clinically robust models of care delivery and subject to evaluation. See [ABS position statement](https://associationofbreastsurgery.org.uk/media/419972/breast-pain-statement-final.pdf) on Breast Pain
* Minimum amount of anxiety and increased breast health awareness for referrals where cancer is not suspected

**For Clinicians**

* Access to appropriate pathways that better meet the needs of people referred with breast symptoms where cancer is not suspected, and allow for imaging and pathology resources to be focused on urgent referrals where cancer is suspected
* Allow clinicians to provide more information to breast cancer patients at the point of diagnosis and have an informed discussion about treatment options at an earlier stage of the pathway
* Streamlining MDT cases and discussions, including potential use of pre-determined diagnostic algorithms. The [MDT toolkit](https://associationofbreastsurgery.org.uk/professionals/clinical/breast-mdtm-toolkit/) is available on the ABS website to support discussions.

**For Systems**

* Effective management of patients who are not suspected to have cancer will reduce demand on imaging and pathology services
* Optimised referral triage and reduced number of inappropriate referrals to resource intensive one stop breast clinic
* Improved quality, safety, and effectiveness of care with reduced variation and improvement in outcomes

# 28-Day Best Practice Timed Pathway (Cancer suspected)

**Local diagnostic centre**

**By Day 28**

**By Day 24**

**By Day 17**

**By Day 10**

**By Day 3**

**Day 0**

**Receipt of referral**

**MDT Discussion of**

**ISH/FISH (where relevant) and Imaging results.**

**MDT Discussion9 of diagnosis including immunohistochemistry (ER, PR, HER2)**

Discuss need for

Genetic Referral or further imaging (e.g. MRI or staging).

**Straight to one-stop clinic** for same day **Examination**, **Mammogram, US6** and **biopsy7** (if required). Frailty Assessment carried out.

**Clinical triage5**

by a suitably trained member of the service into cancer **OR** breast symptomatic\* pathway (below)

**Suspected cancer GP referral 1**

Including a minimum dataset **2** and physical patient examination.

**Patient information**

**Cancer likely, communication and discussion with CNS.** Only record FDS when person is informed that they have cancer **8** OR **Cancer ruled out and communication.** Person informed. Record FDS when person informed that cancer has been excluded **8**

Personalised care and support should continue across the pathway**10**.

**Receipt of referral in Secondary Care** from Screening Assessment clinic after recall for assessment and biopsy.

**Patient information**

Provided in primary care **1**

**Patient information**

Provided at Outpatient Appointment (OPA) **8**or clinic assessment

**Breast Screening (routine and very high risk) patients or those on annual survelillace (family history and post-cancer follow up) 3**

Day 0 is the decision to recall in NHSBSP or the abnormal mammogram report at the local trust.

**Cancer suspected**

**Results clinic visit;**

Clinical Review, **patient informed of diagnosis of cancer or cancer is ruled out**, record FDS,communication with CNS, further tests if required.

**Discuss treatment options** and Personalised Care and Support plan with MDT input, optimisation and support.

Timings shown in this pathway are recommendations only.

See detailed information on pages 16 to 19

# 28-Day Best Practice Timed Pathway (Cancer not suspected)

**By Day 28**

**By Day 14**

**By Day 3**

**Day 0**

**Receipt of referral**

**Local diagnostic centre**

**Clinical triage5**

by a suitably trained member of the service into cancer **OR** breast symptomatic pathway

**Breast symptomatic referral 4\***

e.g. Gynaecomastia (according to ABS/RCGP [Guidelines](https://associationofbreastsurgery.org.uk/media/334381/abs-summary-statement-gynaecomastia-pdt-pictogram.pdf)), Asymptomatic, Breast pain\*,

Implant problem / infection

**Results clinic visit if appropriate;**

Clinical Review, **patient informed of diagnosis of cancer or cancer is ruled out**, record FDS,communication with CNS, further tests if required.

**Discuss treatment options** and Personalised Care and Support plan with MDT input, optimisation and support.

**Assessment in an appropriate setting** (i.e. Bespoke Breast pain\* or surgical follow up clinic). New pathways must be subject to routine data collection and [evaluation](https://associationofbreastsurgery.org.uk/professionals/clinical/breast-pain-pathways/).

For most patients informed cancer is ruled out at first visit and record FDS.

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**Patient information**

Provided in primary care **1**

**Patient information**

Provided at Outpatient Appointment (OPA) **8**or clinic assessment

Only record FDS when person is informed that they have cancer **8** OR **Cancer ruled out and communication.** Person informed. Record FDS when person informed that cancer has been excluded **8**

Personalised care and support should continue across the pathway**10**.

**If cancer is suspected, refer straight to one-stop clinic / MDT on same day (parallel clinic) or next available.**

**These patients should still receive their cancer diagnosis as per FDS, by Day 28.**

**Patient information**

**Cancer not suspected**

Timings shown in this pathway are recommendations only.

See detailed information on pages 16 to 19

## Detailed information

1. **Urgent GP referral** **pathway** should be used for people who meet NG12 criteria for suspected cancer pathway referrals. The National Cancer Waiting Times Monitoring Dataset Guidance v12.0 sets out consultant upgrade rules, including from non-GP scenarios such as A&E and acute settings. Cancer Alliances may agree local arrangements to facilitate self-referral, community diagnostic centres and other referral routes, to access this pathway. Any new arrangements should be audited.

It is noted with the implementation of community diagnostic centres that referral pathways may be subject to change. **Primary care should inform people** that they are being referred for an urgent suspected cancer pathway and that a diagnosis will be provided within 28 days, although stating that vast majority of referrals result in non-cancer diagnoses. Primary care should also make people aware of their responsibilities to make themselves available for the first two weeks for initial diagnostic testing (NICE Quality Standard 12).

‘Choose and Book’ appointments are no longer widely used. Units still using Choose and Book should review patients going into these pathways. Patient choice remains, therefore individuals choosing to have an appointment at a later date will start their FDS 'clock' later.

1. **A minimum dataset to accompany the referral, patients should also be examined in primary care.** GPs shouldfacilitate straight to clinic and immediate diagnostics, to be agreed locally, should include: description of referral reason in line with NG12 guidelines, patient demographics, relevant family history of cancer, performance status, co-morbidities, including diabetes status, dementia, mental health conditions, such as claustrophobia, Body Mass Index, prescribed medication, allergies, family history of cancer, functional / frailty score (e.g. Rockwood) for patients above 70 uploaded to COSD as recommended by the National Audit of Breast Cancer in Older People, presence of metal implants or pacemakers, need for interpreter, mental capacity to consent. Capacity will need to be considered for completing missing dataset tests in the first OPA or one-stop clinic, following referral from primary care.
2. A referral for **Breast Screening Assessment** would only be made after there is consensus that the patient needs to be assessed, whether this is by the initial two readers or after arbitration. Therefore Day 0 is the day of decision to recall for assessment by the NHSBSP. Annual surveillance includes very high risk screening through the NHSBSP, follow-up mammograms and family history surveillance.
3. **Breast Symptomatic\* Referral.** If cancer is not initially suspected, there should be an urgent referral pathway for people with breast symptoms who cannot be managed in primary care. Although not on a suspected cancer pathway, these referrals should still be able to expect an outcome within 28 days of initial referral. Cancer Alliances should ensure that any pathways set up to manage patients with breast pain, gynaecomastia and other non-suspected cancer referrals meet the needs of those patients and are delivered in the most clinically appropriate setting. Breast pain is benign, occurring in approximately 70% of women, is not a sign of cancer, but can take many months to resolve, in the presence of a normal examination patients can be reassured and do not need imaging with a link to information leaflets and videos. Non-suspected cancer pathways should maintain close links into One Stop Clinic services and refer any patients on the pathway that present with red-flag symptoms. Pathways should be developed in line with existing models of care which have already been evaluated, as well as best practice more broadly.
4. **Clinical triage** can be done by a suitably trained member of the service. People who attend an outpatient appointment should have same day investigations to reduce repeat visits and improve experience. All those over 70 should have formal frailty assessment performed at the one stop clinic when a cancer diagnosis is likely (such as [NABCOP Frailty Assessment](https://www.nabcop.org.uk/resources/fitness-assessment-tool/) or electronic Frailty Index)
5. **Mammogram / Ultrasound.** Patientsin whom cancer is suspected should be seen initially in a one stop clinic with access to triple diagnostic assessment in a single hospital visit including availability for same day clinical examination, mammography, ultrasound and biopsy. Imaging should comply with Royal College of Radiologists [Guidelines](https://www.irefer.org.uk/) and [Recommendations](https://www.rcr.ac.uk/publication/recommendations-cross-sectional-imaging-cancer-management-third-edition).

Further imaging should be considered at the diagnostic MDT according to local protocols and in compliance with Royal College of Radiologists’ recommendations. Ring-fenced general cancer CT and MRI slots should be considered to ensure that capacity is available to deliver expected imaging within 8 calendar days of biopsies.

1. **A core biopsy is a prerequisite for diagnosis and development of a management plan**. **Histopathology reports for tissue sampling** should usually be available (including immunohistochemistry) in 7 calendar days. Consider reflex immunohistochemistry for all M5 and/or U5 biopsies. The time taken may be longer if ancillary tests are required to establish a primary diagnosis. In instances where FISH/ISH is required to determine HER2 status, the expectation should be for these results to still be available within the 28-Day pathway as best practice.

All histopathology should have a designated point of receipt, sign-off and management responsibility to ensure the chain of custody is not lost.

1. **Patients and care-givers should be asked** what information they require about the pathway, provided with standard information about investigations when sending confirmation of appointment, confirmation of next step(s) and anything required to prepare for the day, and whether they have any disabilities, language barriers or other factors which may need to be taken into account in regard to service accessibility. Preferences for amount of information and when it is provided will vary, and therefore it will help to provide caseworker / navigator telephone contact details to provide support throughout the pathway, provide signposting to charities and support services, provide information about care-givers attending appointments, and offer follow-up if people do not receive confirmation of appointment in expected timescale. People should also be informed that it is likely they will receive one or more procedures and/or diagnostic tests on the same day, at the first face-to-face appointment. Patients should be given information on what the tests will involve and how long their appointment is likely to last. The one stop clinic appointment may take several hours.

**People should be informed** about cancer being ruled out, or diagnosed at the earliest face-to-face opportunity by default, unless the person has expressed an alternative method of communication in order to speed up communication. In this timed pathway, this can be done at a one-stop clinic, a follow-up testing or results outpatient appointment, or at a treatment planning outpatient clinic. The diagnosis should include the tumour receptor status, i.e. the oestrogen receptor (ER), the HER2 receptor status, and +/- the progesterone receptor (PR). It is recognised that if HER2 fluorescent in-situ hybridisation (FISH/ISH) is required, this may not be available for a further 7 days. In this case, a diagnosis should still be provided within 28 days without FISH/ISH if it is not available in time. Early consideration of a person’s fitness for radical therapy and requirements for pre-habilitation should be addressed as soon as possible in the pathway to minimise delays in expediting treatment. Patients that require a frailty assessment can be assessed using the [NABCOP Frailty Assessment](https://www.nabcop.org.uk/resources/fitness-assessment-tool/) or [electronic Frailty Index (eFI)](https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/) in advance of MDT discussion.

Primary Care should also be informed of the outcome of the urgent referral in a timely manner.

1. **MDT discussion with ER, PR and HER2 further information (where relevant).** The core roles at the full MDT(to be carried out following cancer diagnosis) are lead clinician, radiologist, surgeon, pathologist, oncologist, CNS and relevant AHP, to review investigation results with an MDT coordinator / pathway navigator. An oncologist with experience in breast cancer and a radiologist with an established breast cancer interest should be present at the full MDT. The capacity required to deliver these core roles should be reflected in job plans.  [National guidance on how to maximise effectiveness of MDT meetings](https://www.england.nhs.uk/wp-content/uploads/2020/01/multi-disciplinary-team-streamlining-guidance.pdf) and the use of standards of care is available. Locally agreed, clear criteria for referral to MDT can also support with efficient pathway management. It is unlikely that all necessary management decisions will be made at a single MDT.
2. **Personalised care and support planning** should be based upon the person and clinician(s) completing a Holistic Needs Assessment (HNA) and personalised care and support plan, usually soon after diagnosis. The HNA ensures conversations focus on what matters to the person, considering wider health, wellbeing, practical issues and support in addition to clinical needs and fitness. The personalised care and support plan also enables shared decision-making regarding treatment and care options to be documented.

\*New pilots seeking to address breast pain pathways should maximise patient satisfaction, safety, and cost-effectiveness. They must also be able to provide an outcome for patients within the FDS 28 day timeframe for urgent referrals. There should be named clinical leadership and clear lines of accountability for ensuring these pathways are implemented safely, and for their performance against the FDS.

The [ABS position statement](https://associationofbreastsurgery.org.uk/media/419972/breast-pain-statement-final.pdf) outlines two possible pathways for breast pain management. New breast pain pathways require evaluation. If you are developing a breast pain pathway, please contact the ABS and Breast Cancer Now to ensure you implement a pathway that is already being evaluated or join their service evaluation.

**Secondary / metastatic / advanced breast cancers**

Patients with suspected new advanced or locally advanced breast cancer can present in several ways. If this is the first presentation of breast cancer of any sort i.e. ‘de novo’, or a suspected late relapse (beyond 5 years) from a previous breast cancer, they may present acutely to General Practitioners, A&E, or via other sources. Patients unknown to the breast follow up team should be directed to the Surgical Breast Clinic Service for investigation. Any urgent GP referrals for suspected cancer that are diagnosed as metatstatic disease with an unknown primary are still covered by the FDS.

It is envisaged that most patients that relapse within the 5 year follow up period will access surgical clinics via the Breast Cancer Nurse. Secondary breast cancers that are diagnosed through routine follow up are not included in the FDS but are subject to the 31-day standard for starting treatment from when the treatment decision was made. These are classed as ‘subsequent treatments’ in cancer waiting times data.

# Additional information

## Audit tool

Can be used to undertake a baseline audit of services being delivered and whether sufficient capacity is in place to routinely deliver, identify areas for improvement, select measurements for improvement, and conduct re-audits as part of continuous improvement.

|  |  |  |  |
| --- | --- | --- | --- |
| Day | Pathway step | Service in place? | Capacity in place? |
| 0 | GP referral and locally agreed minimum dataset |  |  |
| Patient information resources, co-developed with patients |  |  |
| 3 | Clinically led triage and local protocols need to be in place to reduce delays |  |  |
| 10 | Straight to clinic provision for all eligible people.  Examination, Mammogram, US and biopsy (if required). Frailty Assessment carried out. |  |  |
| 14 | ‘Cancer not suspected’ patients should be assessed in an appropriate setting (i.e. Bespoke Breast pain or surgical follow up clinic). |  |  |
| 17 | MDT Discussion of diagnosis including immunohistochemistry (ER, PR, HER2), discuss need for further radiology or genetic referral.  Planning of potential treatment options |  |  |
| 24 | For those requiring FISH/ISH for their Her2 status this should be available for further MDT discussion by day 24 (where relevant) |  |  |
| 28 | Clinic appointment to give diagnosis and make treatment plan based on the MDT recommendations. |  |  |

## Cancer Alliance Workspace

Cancer Alliances access this workspace for national guidance, resources, and to share learning. Please use this space to upload materials you have developed locally and that you think would be useful for colleagues implementing this pathway across the country

## Glossary of Terms

|  |  |
| --- | --- |
| Term | Definition |
| ABS | Association of Breast Surgery |
| AHP | Allied Health Professionals |
| CNS | Clinical Nurse Specialist |
| COSD | Cancer Outcomes and Services Dataset |
| CT | Computed Tomography |
| eFI | Electronic Frailty Index |
| EUA | Examination under anaesthesia |
| FDS | Faster Diagnosis Standard |
| FISH | Fluroescent in-situ hybridisation |
| GIRFT | Getting It Right First Time |
| HNA | Holistic Needs Assessment |
| ICS | Integrated Care System |
| ISH | In-situ hybridisation |
| MDT | Multi-disciplinary team |
| MRI | Magnetic Resonance Imaging |
| NABCOP | National Audit of Breast Cancer in Older Patients |
| NG12 | National Institute for Health and Care Excellence’s Suspected cancer recognition and referral guideline |
| NHSBSP | National Health Service Breast Screening Programme |
| NICE | National Institute for Health and Care Excellence |
| OPA | Outpatient Appointment |